

Northumbria Research Link

Citation: Steven, Alison, Larkin, Valerie, Stewart, Jane and Bateman, Belinda (2018) The value of continuing professional development: A realistic evaluation of a multi-disciplinary workshop for health visitors dealing with children with complex needs. *Nurse Education Today*, 67. pp. 56-63. ISSN 0260-6917

Published by: Elsevier

URL: <https://doi.org/10.1016/j.nedt.2018.04.021>
<<https://doi.org/10.1016/j.nedt.2018.04.021>>

This version was downloaded from Northumbria Research Link:
<http://nrl.northumbria.ac.uk/id/eprint/34089/>

Northumbria University has developed Northumbria Research Link (NRL) to enable users to access the University's research output. Copyright © and moral rights for items on NRL are retained by the individual author(s) and/or other copyright owners. Single copies of full items can be reproduced, displayed or performed, and given to third parties in any format or medium for personal research or study, educational, or not-for-profit purposes without prior permission or charge, provided the authors, title and full bibliographic details are given, as well as a hyperlink and/or URL to the original metadata page. The content must not be changed in any way. Full items must not be sold commercially in any format or medium without formal permission of the copyright holder. The full policy is available online: <http://nrl.northumbria.ac.uk/policies.html>

This document may differ from the final, published version of the research and has been made available online in accordance with publisher policies. To read and/or cite from the published version of the research, please visit the publisher's website (a subscription may be required.)

Title page

Title:

The value of continuing professional development: a realistic evaluation of a multi-disciplinary workshop for Health Visitors dealing with children with complex needs.

Authors :

Alison Steven^{a,*}, Valerie Larkin^a, Jane Stewart^b, Belinda Bateman^c

^a Northumbria University Newcastle
Department of Nursing Midwifery and Health
Coach lane campus
Benton
Newcastle upon Tyne
NE77XA
UK

Tel: +44 1912156483*
Alison.steven@northumbria.ac.uk *
val.larkin@northumbria.ac.uk

^b Newcastle University & Northumbria Health Care NHS Foundation Trust
School of Medical Education
The Medical School
Ridley Building 1
Newcastle University
NE1 7RU
UK
jane.stewart@newcastle.ac.uk

^cBelinda Bateman,
Northumbria Health Care NHS Foundation Trust
North Tyneside General Hospital
Rake Lane
North Shields
Tyne and Wear
NE29 8NH
UK
Belinda.Bateman@northumbria-healthcare.nhs.uk

Acknowledgements

We wish to acknowledge and thank Barabara Stanton and Dr Deborah Goodall for their contribution to the development of this research project. We acknowledge the funding made available by Northumbria Healthcare NHS Foundation Trust and Northumbria University Higher Education Innovation Fund which enabled this study to take place.

ACCEPTED MANUSCRIPT

Abstract

Background: Continuing Professional Development is important for maintaining and developing knowledge and skills. Evidence regarding direct impact on practice is limited. Existing literature often lacks sufficient detail regarding the initiative or its evaluation, making transferability problematic.

Objective: To explore the impact and perceived value of multi-disciplinary Continuing Professional Development workshops for Health Visitors who support families with children with complex health needs.

Design: Realistic Evaluation principles guided the research. Workshop attendees were invited to participate (n.21), 81% (n.17) agreed. Data collection included a questionnaire and semi-structured interviews. Data analysis included descriptive statistics and qualitative thematic analysis.

Setting: One North of England Health Service Trust.

Findings: Interrelated temporal themes emerged. Before the workshop expectations included, uncertainty regarding content and ambiguity regarding attendance. During workshops comments focused on networking opportunities, the detail, content and facilitation of the learning experience. 'Emotional safety' enabled interaction, sharing and absorption of information, and potentially increased trust, confidence and social capital. Participants viewed the workshop as informative, enhancing insight regarding roles, services and processes. Post-workshop participants reported examples of practice enhancements attributed to workshop attendance including: confidence building; improved team working; facilitation of early referral and accessing additional support for families.

Conclusions: Findings suggest initiative developers aiming CPD at new or existing teams need to consider nurturing social capital and to pay attention to the context and mechanisms, which can prompt attendance, engagement and subsequent practice application.

INTRODUCTION AND BACKGROUND

Continuing Professional Development (CPD) is considered an important component to maintaining and developing the knowledge and skills of the healthcare workforce, contributing to safe and effective professional practice (Rafferty, Xyrichis and Caldwell, 2015). This is reinforced in the United Kingdom (UK) by the Nursing and Midwifery Council (NMC) standards which include mandatory revalidation requirements specifying that all nurses, midwives and health visitors must complete 35 hours of continuing professional development (CPD) activity every 3 years (NMC, 2015). However, as funding for educational initiatives becomes increasingly scrutinised within a financially constrained health service, so too is the value of face-to-face educational events (Greatbatch, 2016).

Gijbels et al. (2010) undertook a systematic review of post-registration nursing and midwifery education focused specifically on the impact on practice from the perspective of nurses, midwives, patients, carers, education and health service providers. Sixty-one (61) studies met the inclusion criteria and were mainly of a retrospective and descriptive nature, with the majority of studies undertaken in the UK, Australia and the USA. The findings suggest that health care professionals benefit from post-registration programmes, applying their newly acquired attitudes, knowledge and skills. However, Gijbels et al. (2010) highlight there has been a tendency in the published work to provide limited detail regarding the educational initiative and its associated evaluative research design, obscuring the ability of the reader to fully comprehend and make decisions about the quality and transferability of the findings. The review identified limited available evidence of the direct impact on organisational and service delivery changes, and on benefits to patients and carers, with further research recommended.

However, the impact of educational interventions is not simple. Olsen and Tooman (2012) suggest the practice of assessing and valuing educational methods based only on their capacity to directly influence practice reflects an impoverished understanding of how change in clinical practice actually occurs, with little attention to the context of the CPD initiative and the agency of the learners. Findings from a large, , mixed-method research programme in the UK highlight the impact organisational culture has upon the ability of staff to innovate, work effectively and provide high quality patient care, with poor organisation, information and levels of staff support a key inhibitory factor (Dixon-Woods et al., 2014). Therefore, for CPD to be valued and seen as effective it must addresses the needs of individual clinicians as well as the populations they serve and the organisations within which they work (Schostak et al., 2010). The review by Rampatige et al., (2009) suggest practitioners need to take an active role in their learning with interactive, multifaceted CPD interventions, and interventions with repeated inputs being more effective in bringing about positive practice changes than non-interactive techniques. In addition, to maximise the potential for CPD to equate with knowledge translation and enhanced practice, the context must be supportive, involving all levels of the organisation, and providing organisational and peer support (Bantwini, 2009; Govranos and Newton, 2014; McNally et al., 2012; Stolee et al., 2005).

This paper presents a detailed and transparent discussion of the content, evaluative strategy and research findings from a CPD initiative. The findings are discussed in light of the wider literature and research maximising the potential for transferability and contributing to the evidence base.

THE EDUCATIONAL INITIATIVE

In response to a growing population of children with complex health needs, health visitors (HVs) who are Specialist Community Public Health Nurses, are increasingly involved in multi-disciplinary teams (MDT) (Public Health England, 2016). To ensure HVs can respond effectively to client needs

professional guidance suggests they may benefit from CPD opportunities (Bishop, Gilroy & Stirling, 2015).

In response in 2014 a half-day workshop was developed in a North of England NHS Trust. The workshop ran twice and aimed to provide information on and opportunities to discuss:

- Children with complex health and developmental needs
- How multi-disciplinary team members may contribute and support such needs
- New ways of working –including the team around the family meetings
- A mechanism to facilitate peer and team support

In addition to the 21 HV attendees, members of the wider multi-disciplinary team (MDT) also participated with the aim of sharing information about their roles and services. MDT participants included physiotherapists, speech and language therapists, dieticians, local voluntary sector representative, occupational therapists and community children's nurses.

The workshop format (see Figure 1) was designed to create maximum opportunities for discussion and to engage both the HVs' semantic and episodic memory (Eraut, 2004), allowing them to share similar experiences and learn from alternate approaches to management. The MDT members with different backgrounds could challenge formulaic thinking and introduce alternative, profession-specific perspectives. Facilitators moved around the groups challenging participants to think more critically and beyond their initial insights by asking 'what if' questions.

Figure 1: Workshop format

EVALUATION METHODOLOGY

The study drew upon Realistic Evaluation (RE), which proposes that causal powers reside not in objects or individuals but in the social relations and organisational structures they form (Pawson and

Tilley 1997). Therefore relationships between causal mechanisms (e.g education) and outcomes (e.g. learning experiences, and resulting activity) are not fixed but contingent on contextual factors (e.g. education methods, practice setting and culture). Pawson (2013) recently highlighted how evaluations often focus on participants' responses to initiatives (outcomes) and overlook strategies used to 'journey through' them. Pawson argues while participants' perceptions of their experiences are important, there is a need to look beyond experiences to seek where and when sometimes hidden and pre-existing latent mechanisms reveal themselves and come into play (Pawson, 2013 p.117). This study draws on the original RE work of (Pawson and Tilley 1997) but also attends to issues of journeying and latent mechanisms (Pawson, 2013). The research team is multi-disciplinary and therefore brought a range of experience and perspectives to the study.

The evaluation aimed to explore

- Participants' immediate perceptions of the workshops including: interaction, engagement and learning context.
- Short and medium term perceptions following the workshops including: value, relevance and application to practice.

Ethics and Recruitment

Ethical and governance procedures were adhered to (DoH, 2005; HRA, 2014). Ethical approval was gained and the proposal agreed by the NHS Trust involved. Recruitment was undertaken by the research team with information distributed several days before the workshop ensuring sufficient decision-making time. Participation (see table 1) was voluntary with consent gained before the workshop, on the day and at subsequent data collection (see table 2). All participants were assigned a code and all data was rendered anonymous. Interviews were recorded and transcribed verbatim.

Table 1: Workshop attendees and study participants

Design and methods

Data collection methods included observation, questionnaire and interviews, over 8 months (by ** & ** see table 2). The questionnaire provided an overview of participants' initial thoughts after the workshop (see table 2) and guided development of an in-depth interview schedule (Kvale, 1996). Potential concepts and ideas for exploration at interview were developed from consideration of the background literature, the research aims and the post-workshop questionnaire results. This approach is useful in initiating an inquiry process and developing questions which facilitate participant disclosure and emerging themes (Cresswell 2013). Semi structured telephone interviews were undertaken at two points (approximately 3 months and then 6 to 8 months post workshop). This approach provided a detailed account of participants' thoughts, activities and practice. Areas of questioning in interview 1 included: activity; relevance and application of the workshop to everyday practice; knowledge or skills gained; perceptions of worth and value of the workshop. At interview 2 similar areas were covered with additional questions regarding putting learning into practice, and perceptions regarding factors supporting or hindering the embedding of learning gained at the workshop into practice. The interview guide acted as a prompt, it identified areas for initial exploration and provided clarity between the two researchers regarding the interview intentions. However, in accordance with principles of semi-structured qualitative interviews, the interview guide was not followed in a prescriptive manner, as each Health Visitor's narrative was unique provoking a unique response, which in turn evoked a particular follow up question (Cresswell 2013).

Table 2: Data collection mapped to study objectives and methodology (C = Context, M = Mechanisms, O = Outcomes)

Analysis

Qualitative data from questionnaires, interviews and observation notes were manually coded using C,M,O definitions as a broad framework (see table 2) whilst allowing additional areas to emerge inductively. Data was managed via a series of shared documents and spreadsheets. Initial thematic analysis was undertaken independently by two researchers (**,**) who then compared and discussed emerging findings which were fed into subsequent data collection (medium term interviews), thus following principles of constant comparison (Strauss and Corbin, 1990). Data was first coded into 'chunks' (e.g before the session, during and after) followed by reduction into smaller categories (e.g changing needs, uncertainty, interactivity, reciprocity, workload pressures) which sought both similarities and differences, whilst attending to C,M,O characteristics, latent mechanisms and notions of journeying (Pawson 2013). Grouping and regrouping categories then formed larger themes (e.g., expectations, learning experiences, emotional safety for learning, enhancing practice). Researchers then returned to the transcripts to further populate and refine categories and themes and try out emerging C,M,O configurations. Comparisons were made across data from the 2 workshops and across data collection points. Questionnaire data was analysed using descriptive statistics (percentages and simple response differences) to highlight commonalities and differences.

Quality and Rigour

Trustworthiness consists of credibility, dependability and transferability and is essential to the quality of qualitative research (Graneheim and Lundman 2004, Seale 1999). Clarity and detail regarding the participants and the workshop format increases transferability of findings (Seale 1999). Credibility and dependability were ensured via collection of descriptive data reflecting real experiences from a variety of sources, independent initial analysis and team data workshops. During data workshops (n= 3) the team (6 people from various backgrounds including Nursing, Educational

research, Information science, Midwifery, Medicine and Health Visiting) discussed, challenged and debated: analysis, findings and interpretations.

In addition, an integral aspect of trustworthiness is reflexivity, an in-depth self-awareness of strengths, limitations and perspectives (Lincoln and Guba 2000) which ensures assumptions are explored and made explicit, thus enabling them to be challenged and therefore safeguarding against pre-conceptions entering the analysis unless they are evident in the data (Robson 2002). The multiple perspectives brought to bear on the data and analysis process during research team meetings, data workshops and at external presentation of findings, enabled assumptions to be regularly explored thus enhancing trustworthiness.

FINDINGS

Questionnaire

Participants reported between 1 to 32 years of working as a HV (mean of 12 years) and mixed caseloads including between 1 and 10 children with complex needs (mean of 4). Half of the respondents highlighted the local context, utilising terms such as “deprivation” a “range of social classes” suggesting this was significant for their practice. Quantitative results (Table 3) show almost all respondents valued the workshop and reported gaining new insights and ideas for their practice.

Table 1: Questionnaire results

Qualitative findings

Findings were consistent across short (3 month) and medium term (6 – 8 month) interviews.

Interrelated themes related to different time points: before, during or after workshop attendance (temporal aspects).

Prior to the workshop: Expectations

Expectations included uncertainty regarding workshop content and ambiguity about attendance.

“to be honest, I went to the training and I didn’t really know exactly what it was going to involve” HV A

For many, expectations and desire to attend was driven by changes in practice, services provided or client’s needs and a need to feel ‘up to date’.

“it would have been nice if I’d been aware of a lot of the things that were going on... But I wasn’t aware of them, you know, so I kind of felt: gosh, I should be aware of these things” HV L

These changes led to some feeling they needed additional guidance and support to ensure they could negotiate such practice changes confidently.

“sometimes there is sort of gapswe’ve had sort of issues in the past where you know, they’ve potentially needed referral into CAMHS because of their age and things, or they don’t meet the criteria and you kind of holding on to this child going “Okay, where do I go next?”” HV B

The study was not designed to explore prior perceptions and therefore the spontaneity of remarks indicate some uncertainty regarding workshop content and highlight the importance of prior expectations. Thus a series of latent, contextually linked mechanisms such as service re-configurations and case load changes provoking feelings of reduced self-confidence may have come into play prior to the workshops and prompted attendance.

During the workshop: The Learning Experience

All participants found the workshop informative, regardless of length of service. .

“Definitely useful for me, being new into health visiting anyway” HV F

"I'm a very experienced health visitor and I've worked for a long time, so a lot of it was just reinforcing what I already know, but that wasn't a negative, because I think it just confirms what you do know, which is sometimes helpful, as well as what you don't know." HV E

Data suggested the informative nature of the workshops pertained to three aspects; roles, services and processes.

"It was valuable actually, meeting the other professionals, some who I didn't know and some that I wasn't 100% clear of what their roles were." HV E

"it was just useful to know what other services do exactly and when's an appropriate time to refer or get in touch" HV C

"How their processes worked as well, How they'd received referrals; what happened when they'd received them and just giving that understanding of the process that's going to happen. It makes it easier to explain to families as well" HV F

Many valued the opportunity to network and the resulting ability to place a face with a name. This human contact was important in enhancing confidence to subsequently contact services and in facilitating communication.

"it certainly increases my confidence. That when I've spoken to somebody face to face, that I feel as if I can ring them again," HV K

it was kind of good for a bit of networking, really and getting to meet people in advance [of working with them]." HV C

"in terms of sort of the social aspect of everybody knowing each other who's involved with this child is a good thing. . . . 'Cos it just means that you can communicate better and get the right things in place" HV L

When asked what influenced the learning experience, participants suggested the interactive teaching strategy, encouraged sharing of experiences and ideas, getting to know one another and learning together.

"It was as interactive session, where we [multiple agencies]all... You know, they swapped tables and everything. Erm, and we spoke about our individual roles, so it wasn't just somebody actually standing up in front of you and talking." HV Q

"You tend to just stay with who you know really, and I think it was moving and going into the different groups gave you that opportunity to speak to the other professionals that were there from different teams that you probably wouldn't usually [talk to]" HV F

"I think [name] led it in a very sort of relaxing... It felt comfortable, it wasn't sort of intense; it was sort of... the opportunity was there to sort of, you know, talk to people and I think [name] led it in a sort of very positive way" HV A

Although MDT members were initially invited as 'givers' of information conversations with researchers during the workshops suggested the interactive approach facilitated learning by all attendees. While some mentioned time constraints many comments highlighted the sharing nature of the experience and the way in which interactions felt reciprocal.

"there was no hierarchy in the group, was there and it was very relaxed, informal, but very structured, so I think that provided the opportunity for people to feel... Well, certainly, it made me feel comfortable and relaxed; to feel confident in sharing my thoughts and experiences." HV E

"Everyone was involved and you got to talk to a wide group of people from multi disciplines."
HV L

"felt as if everybody was able to have their say and you know, give information." HV K

However, some participants considered more attention was needed to ensure two-way flow of information. The language used to describe experiences implies varying degrees of reciprocity, a lack of which seems to have negatively impacted.

“nobody sort of said: “What do the health visitors do?” ...Yes, everyone was giving us all their information, which was lovely, but no one sort of said, you know, “what do you do?” HV J

“It felt a little bit like I was a child at school, you know? “What do you think I do?” And when I didn’t quite get it right, I was sort of scolded a bit for it.” HV H

While two participants felt they had a detailed knowledge base from prior experience and gained little from attending, others emphasised the relevance of the workshop to their current case load:

“I had a child in my head throughout the whole process” HV K

“I have got quite a few children on my caseload with additional needs, so it was really useful for me to be able to attend.” HV B

“I found it useful. I felt it was helpful for my practice currently.” HV E

Thus perceptions regarding prior knowledge and relevance seemed to influence engagement and learning.

It seems for some the interplay between interactivity, reciprocity and relevance created a learning environment and experience which felt safe and comfortable. This can be viewed as a transient contextual state.

“I found the format of the afternoon very relaxed a friendly open atmosphere ..so very positive... it made me feel comfortable and relaxed; confident in sharing my thoughts and experiences.” HV E

“I think everyone was.. transparent, welcoming, receptive to advice, willing to ask questions. You know, you didn’t feel like... You were fine to ask them what they thought. Everyone was wanting to share their skills and information” HV J

Post workshop: Practice Enhancement

Participants were asked about professional activity following the workshop, including if they had instigated any actions they considered a result of their attendance. HVs suggested the knowledge gained regarding roles and services, together with links formed, enhanced their confidence to contact other services.

“Once you’ve met people face to face, it’s not as daunting ringing somebody who you’re thinking: well I don’t know what they’re going to say; are they going to expect me to know more about this service than I do? And I think that’s often one of the daunting things about sort of picking up the phone” HV B

There was a sense of increased collegiality illustrated by mentions of closer working relationships, which enhanced patient care.

“We’ve done a joint visit together, with them working so closely and it’s just much more seamless for the family.” HV F

“I was concerned about speech and language and I probably would have left it a bit...[but]. I phoned up and got some advice .. they were very helpful. They didn’t mind me ringing them up and they didn’t mind like, sharing the information” HV J

“I thought.. I’m going to contact them [other service]– because I wasn’t aware of that role. So that came as a result of going there [to the workshop]” HV G

The added information and human connections engendered feelings of being supported and empowered the HVs to access additional services. HVs also appeared more able and willing to lead collaborative initiatives and in some cases reported making earlier referrals.

“After the course I was really concerned about things [regarding a child] and I really pushed to bring a meeting together ... I just felt as if I was more confident that yes, it was part of my role to push this child’s needs to the forefront and get this meeting off the ground” HV K

I’ve actually referred to the occupational therapist for another family earlier” HV A

The main inhibitory factor in applying learning from the workshops appeared to be workload pressures. These included limited time and dealing with competing demands.

There are never enough hours in the day... it’s not just about the numbers of families; it’s actually the quality of the families that we have, the complex needs that some of the families have... It’s just mammoth.” HV Q

Although these ‘contextual issues’ hindered the HVs in using what they gained at the workshops, the data suggests that attending gave HVs information, knowledge and networks, enhanced confidence both to instigate changes, access additional support and in some cases make earlier referrals. Given the timing of data collection (6-8 months) it seems that these gains and practice changes were sustained in the medium term.

DISCUSSION

This study illuminates how the CPD workshop format facilitated HVs to gain knowledge, build networks and relationships, and develop confidence. In some cases, these gains translated into reported practice changes, sustained in the medium term. The methodology enabled findings to be conceptualised as a series of factors (contexts and mechanisms) which interact and influence

outcomes. Pawson (2013 p.14) has criticised some who purport to use realistic evaluation for their lack of an explanatory focus, and ‘failure to investigate contexts, mechanisms and outcomes in configuration’. Thus after initial thematic analysis the researchers (** & **) re-examined the temporal themes, the mechanisms (contextual and otherwise) and the outcomes to develop a detailed configuration (figure 2), providing an explanatory summary.

Figure 2: CMO configurations conceptualised

Some mechanisms are latent, context bound and external to the workshop. For example, prior to the workshop changes to service provision and practice processes constituted issues to be ‘dealt with’ and responded to by HVs and the wider MDT. King (2015) explored HV reactions to changes to practice following policy modifications and reported low morale and feelings of vulnerability. Such emotions may be likened to the feelings of uncertainty and doubt regarding being ‘up to date’ expressed by participants in this study, potentially indicating lowered self - efficacy. Some HVs reported uncertainty about workshop aims and content, potentially influencing motivation to attend. Previous work has highlighted that many nurses perceive CPD as mostly being mandatory training (Philippou, 2011). In this study, the individual’s self-efficacy and their perceptions of the workshop content seemed to act together as mechanisms influencing the outcome of ‘attendance’.

The ‘self-selection’ effect is often quoted in relation to initiative evaluations and transferability of findings, however as Pawson (2013, p.118) proposes, and this study indicates, there are often invisible mechanisms at play long before participants attend. All CPD initiatives either voluntary or mandatory may be subject to such mechanisms which could influence attendance and, or engagement. It is interesting that data collection did not purposively elicit prior perceptions; these were provided spontaneously indicating their importance to participants. This suggests adequate

preparation and information prior to CPD workshops is helpful in maximising motivation to attend, particularly when potential links to contemporary contextual issues such as policy or practice changes are emphasised (King, 2015; Philippou, 2011).

During the workshops other mechanisms came into play: latent mechanisms such as time limits and existing knowledge, and more personal 'active' mechanisms such as interactivity and reciprocity. These findings are supported by Bluestone et al., (2013) who concluded interactive methods of CPD are associated with a more favourable evaluation and increased likelihood of content being applied to practitioners' subsequent practice. In this study mechanisms combined leading to a learning atmosphere where participants felt comfortable to disclose, challenge and share. This appeared particularly important in the final section of the workshop in which participants moved from abstract considerations to reflecting upon their own caseload and helping one another deconstruct the challenges faced. This atmosphere was akin to 'emotional safety for learning' (Steven et al., 2014), a temporal state in which participants feel relaxed and safe to discuss concerns, experiences and areas of uncertainty. This state is both an 'outcome' of a combination of reciprocity, relevance and interactivity and a 'mechanism' enhancing learning. Emotional safety enables interaction, sharing and absorption of information, potentially increasing trust and confidence, thus facilitating the development of social capital (Bourdieu, 1986; Hofmeyer and Marck, 2008; Rostila, 2010; Stromgren et al., 2016).

While multiple definitions of social capital exist at the individual and collective level (Rostila, 2010; Bourdieu, 1986), the term broadly refers to actual or potential resources embedded in and emerging from, social relationships. The structural dimensions of forms of social capital include linking, bonding and bridging (Hofmeyer and Marck, 2008; Rostila, 2010). In relation to nursing Stromgren et al. (2016 p.117) focused on workplace social capital, defining it as 'a relational resource, e.g. the occurrence of networks, norms and trust promoting coordination and collaboration for a common good'. The development of social capital is associated with trusting relationships, reciprocity and

recognition (Bordieu, 1986) and is viewed as important for job satisfaction (DiCicco-Bloom, 2007; Stromgren et al., 2016), creation of safer care (DiCicco-Bloom, 2007; Hofmeyer and Marck, 2008;) and successful professional engagement in clinical improvements (Stromgren et al., 2016). Thus the reciprocity, interactivity and networking which emerged in this study can be posited as indicating development of social capital among the HVs, facilitators and MDT members who attended.

HVs suggested the workshop enhanced their practice by developing their confidence, promoting team working and enabling access to additional support which in some cases seemed to engender actions such as early referral. Post workshop mechanisms, such as time pressures and caseload, influenced HVs' potential to operationalise the social capital gained, thus inhibiting translation into practice of gains from workshop attendance. Other contextual issues, such as reorganisation of services and new processes may have compounded this translation. Indeed research suggests not knowing how to access support, or a lack of follow up subsequent to learning activities may hinder the ability of health care staff to change and develop their practice (Lee, 2011). Longitudinal research would be necessary to ascertain if, or to what extent, social capital engendered via workshop attendance in this study may be 'dormant' and become accessible in the future.

Study Limitations

It is important to acknowledge that while realistic evaluation enabled an illumination of C,M,Os involved in how the workshops 'worked', it did not and could not, fully answer the question 'do workshops work in changing practice?' Such a question requires a different, more longitudinal study and given the constantly changing landscape of health and social care, may be impossible to answer. Realistic evaluation purports a goal of 'continual betterment of practice' (Pawson and Tilley, 1997 p.119) rather than seeking generalizable answers to 'does it work?' questions.

We acknowledge this is a small, geographically and temporally located study and as such may have limited generalisability. However the multi-disciplinarity of the research team enabled a range of perspectives to be brought to bear on the study and allowed challenging and questioning of

emerging findings. We believe the strengths of this study are the analysis which goes beyond the mere description often found in evaluation research, and the conceptualisation of C,M,O configurations which may have transferability and resonance for others.

CONCLUSION

This paper has highlighted the value of CPD workshops for HVs. The interplay between mechanisms seemed to engender a series of outcomes: some transient such as the state of emotional safety for learning; some with longer-term potential such as network development and informative learning. While information and networks can be conceptualised as outcomes in their own right, they also act as mechanisms pivotal to the development of other post-workshop outcomes including access to support, teamwork and confidence development, if contextual conditions such as collegiality, workload pressures and case mix permit. Thus workshops are posited as engendering the formation of social capital. The ultimate aim of practice enhancement therefore seems dependent upon a whole series of context, mechanisms, outcome configurations lining up throughout the participants' 'learning journey'.

In times of austerity, and in a bid to have an educational reach that goes further and wider, online resources are often seen as a panacea for funding constraints and an effective way of reducing time away from the workplace. Cutting the need for expensive resources such as teachers, as well as allowing a significant number of staff to be 'taught' using the same materials, may offer a standardisation of approach and perhaps suggest the holy grail of education – homogenous outputs. However, such an approach does not reflect the need to consider CPD activity as a means to not only maintain practice but also to develop practice, with interaction a key component enabling practitioners to engage in debate, develop networks, support and the resulting social capital to advance their practice (Bluestone et al., 2013; Greatbatch, 2016; Rafferty, Xyrichis & Caldwell, 2015). We suggest that initiative developers aiming CPD at new or existing teams need to consider

nurturing social capital and to pay attention to the context and mechanisms, which can prompt attendance, engagement and subsequent practice application.

ACCEPTED MANUSCRIPT

REFERENCES

- Bantwini, B. D., 2009. District Professional Development Models as a Way to Introduce Primary-School Teachers to Natural Science Curriculum Reforms in One District in South Africa. *Journal of Education for Teaching: International Research and Pedagogy*. 35, 169-182.
- Bishop, P., Gilroy, V., Stirling, L., 2015. A National Framework for Continuing Professional Development for Health Visitors. http://ihv.org.uk/wp-content/uploads/2015/09/iHV_Framework-CPD-standardsAW-WEB.pdf (accessed 13/04/17).
- Bluestone, J., Johnson, P., Fullerton, J., Carr, C., Alderman, J., and BonTempo, J., 2013. Effective in-service training design and delivery: evidence from an integrative literature review. *Human Resources for Health*. Oct 1, 11(51), doi: 10.1186/1478-4491-11-51.
- Bordieu, P., 1986. The forms of Social Capital, in: Richardson, J.G., (ed) *Handbook of Theory and Research for the Sociology of Education*. Greenwood Press, New York. pp. 241-258.
- Cresswell, J., W., 2013. *Qualitative Inquiry & Research Design. Choosing Among Five Approaches*. 3rd Edition. Sage, London.
- DiCicco-Bloom B., Frederickson K., O'Malley D., Shaw E., Crossan J.C., & Looney J.A., 2007. Developing a model of social capital: relationships in primary care. *Advances in Nursing Science* 30, E12–E24.
- Department of Health, 2005. *Research governance framework for health and social care*. Second edition. Available at: <https://www.gov.uk/government/publications/research-governance-framework-for-health-and-social-care-second-edition> (Accessed 30/6/16).
- Dixon-Woods, M., Baker, R., Charles, K., Dawson, J., Jerzembek, G., Martin, G., McCarthy, I., McKee, L., Minion, J., Ozieranski, P., Willars, J., Wilkie, P., West, M., 2014. *Culture and behaviour in the*

English National Health Service: overview of lessons from a large multimethod study. *BMJ Qual Saf.* 23 (2), 106-115.

Eraut, M., 2004. Informal Learning in the Workplace. *Studies in Continuing Education.* 26 (2), 247-274.

Gijbels, H., O'Connell, R., Dalton-O'Connor, C., O'Donovan, M., 2010. A systematic review evaluating the impact of post-registration nursing and midwifery education on practice. *Nurse Education in Practice.* 10, 64 – 69.

Govranos, M., Newton, J., M., 2014. Exploring ward nurses' perceptions of continuing education in clinical settings. *Nurse Educ Today.* 34(4), 655-60. doi: 10.1016/j.nedt.2013.07.003

Graneheim, U.H. & Lundman, B. 2004. 'Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness,' *Nurse Educ Today* , 24, 105-112.

Greatbatch, D., 2016. A false economy: Cuts to Continuing Professional Development funding for nursing, midwifery and the Allied Health Professions in England. Council of Deans for Health, [Online]. Available at <http://www.councilofdeans.org.uk/wp-content/uploads/2016/09/19092016-A-False-Economy-CPD-cuts-in-England-2016-17-.pdf> (Accessed 28/2/17).

Lincoln, Y.S. and Guba, E.G. 2000. 'Paradigmatic controversies, contradictions, and emerging confluences.' In Denzin, K. & Lincoln, Y.S. (Eds) 2000. *Handbook of Qualitative Research.* 2nd Edition, London: Sage Publication.

Health Research Authority, 2014. Consent & Participant Information Sheet Preparation Guidance. Available at: <http://www.hra-decisiontools.org.uk/consent/docs/Consent%20and%20PIS%20Guidance%20Mar3rd2014.pdf> (Accessed 30/6/16).

Hofmeyer, A., Marck, P. B., 2008. Building social capital in healthcare organisations: thinking ecologically for safer care. *Nursing Outlook.* 56, 145-151.

King, C., 2015. Health visitors' accounts of the impacts of 'Hall 4' on their practice and profession: a qualitative study. *Community Practitioner*. 88(2) 24-27.

Kvale, S., 1996. *Interviews: An Introduction to Qualitative Research Interviewing*. Sage, London.

Lee, N.J., 2011. An evaluation of CPD learning and impact upon positive practice change. *Nurse Education Today*. 31, 390 – 395.

McInally, W., Masters, H., Key, S., 2012. The impact of paediatric oncology education on clinical practice - A phenomenological study. *European Journal of Oncology Nursing*. 16, 498-504.

NHS Health Education England. Health Careers: Health Visitor. Available at:

<https://www.healthcareers.nhs.uk/explore-roles/public-health/roles-public-health/health-visitor>
(Accessed 04/12/17)

NHS England (2014) NHS England: MDT Development - Working toward an effective multidisciplinary/multiagency team. Available at: <https://www.england.nhs.uk/wp-content/uploads/2015/01/mdt-dev-guid-flat-fin.pdf> (Accessed 04/12/17)

Nursing & Midwifery Council, 2015. Revalidation: How to revalidate with the NMC. Available at: <https://www.nmc.org.uk/globalassets/sitedocuments/revalidation/how-to-revalidate-booklet.pdf>
(Accessed 16/5/17)

Olson, C. A., Tooman, T. R., 2012. Didactic CME and practice change: don't throw that baby out quite yet. *Adv in Health Sci Educ*. 17:441–451. DOI 10.1007/s10459-011-9330-3

Pawson, R., 2013. *The science of evaluation : a realist manifesto*. London, Sage.

Pawson, R., and Tilley, N., 1997. *Realistic Evaluation*. London, Sage.

Philippou, J., 2011, *Career Management in Nursing: An Examination of the Views of Employers and Employees*. Cited in: Rafferty, A.M., Xyrichis, A., Caldwell, C., 2015. Post-graduate education and career pathways in nursing: a policy brief. National Nursing Research Unit: London. [Online]

Available at: <https://www.kcl.ac.uk/nursing/research/nrru/publications/Reports/PG-Education-Policy-Brief-March-2015.pdf> (Accessed 30/6/16).

Public Health England, 2016. Best start in life and beyond: Improving public health outcomes for children, young people and families Guidance to support the commissioning of the Healthy Child Programme 0-19: Health Visiting and School Nursing services. [Online]. Available at: <https://www.gov.uk/government/publications/healthy-child-programme-0-to-19-health-visitor-and-school-nurse-commissioning> (Accessed 30/6/16).

Rafferty, A.M., Xyrichis, A., Caldwell, C., 2015. Post-graduate education and career pathways in nursing: a policy brief. National Nursing Research Unit: London. [Online] Available at: <https://www.kcl.ac.uk/nursing/research/nrru/publications/Reports/PG-Education-Policy-Brief-March-2015.pdf> (Accessed 30/6/16).

Rampatige, R., Dunt, D., Doyle, C., Day, S., Van Dort, P., 2009. The effect of continuing professional education on health care outcomes: lessons for dementia care. *International Psychogeriatrics*. 21, Supplement 1, S34 –S43. doi:10.1017/S1041610209008746.

Robson, C. 2002. Real world research. 2nd Edition, Oxford: Blackwell publishing.

Rostila, M., 2010. The facets of social capital. *Journal for the Theory of Social Behaviour*. 41(3), 308-326.

Schostak, J., Davis, M., Hanson, J., Schostak, J., Brown, T., Driscoll, P., et al. Effectiveness of Continuing Professional Development project: a summary of findings. *Med Teach*. 32(7), 586–592.

Seale C. 1999. The Quality of Qualitative Research. Sage, London.

Steven, A., Magnusson, C., Smith, P. and Pearson P.H., 2014. Patient safety in nursing education: Contexts, tensions and feeling safe to learn. *Nurse Education Today*. 34, 277-284.

Stolee, P., Esbaugh, J., Aylward, S., Cathers, T., Harvey, D. P., Hillier, L. M., Keat, N. & Feightner, J. W., 2005. Factors associated with the effectiveness of continuing education in long-term care. *The Gerontologist*. 45, 399-409.

Strauss, A. L., Corbin, J. M., 1990. *Basics of Qualitative Research: Grounded Theory Procedures and Techniques*. Sage, London.

Stromgren, M., Eriksson, A., Bergman, D., Dellve, L., 2016. Social capital among healthcare professionals: a prospective study of its importance for job satisfaction, work engagement and engagement in clinical improvements. *International Journal of Nursing Studies*. 53, 116-125.

Tolson, D., McIntosh, J., Loftus, L., Cormie, P., 2007. Developing a managed clinical network in palliative care: a realistic evaluation. *International Journal of Nursing Studies*. 44, 183-195.

Table 1: Workshop attendees and study participants

	Workshop 1 N=	Workshop 2 N=	Total
Workshop attendees	10	11	21 (100%)
Study participants	8	9	17 (81%)
Completed questionnaire	6	9	15 (71%)
Completed Interview 1	8	7	15 (71%)
Completed Interview 2	5	5	10 (48%)

Table 2: Data collection mapped to study objectives and methodology (C = Context, M = Mechanisms, O = Outcomes)

Broad definitions used in the study		
<ul style="list-style-type: none"> Context (C)-the culture, routines, work structures within which participants operated. For example, related to working conditions, processes or the population with whom HVs worked. Mechanisms (M) – interactions, relationships, activities or circumstances which influenced or impacted on participants 'learning' and feelings of confidence or competence. Outcomes (O)- any changes in the confidence, competence, knowledge, skills or activities Such changes may be observed, perceived or reported. 		
Objectives. Describing & exploring: Data	<i>The sessions as enacted (on the day)</i>	<i>Subsequently (short and medium term)</i>
	<ul style="list-style-type: none"> Participants' interaction/ engagement (C,M) Learning milieu and context (C,M) Participants' perceptions (Immediate) (M,O) 	<ul style="list-style-type: none"> Perceptions of value, worth, gain (M) and impact (M,O) Relevance and application to everyday practice (M,O) Possible and actual resulting activity (M,O)
Observation of sessions: Field notes	X	
Questionnaire (taking approximately 10-15 minutes to complete): Immediately after session (11 questions open and closed) covering : Participant demographics &	X	

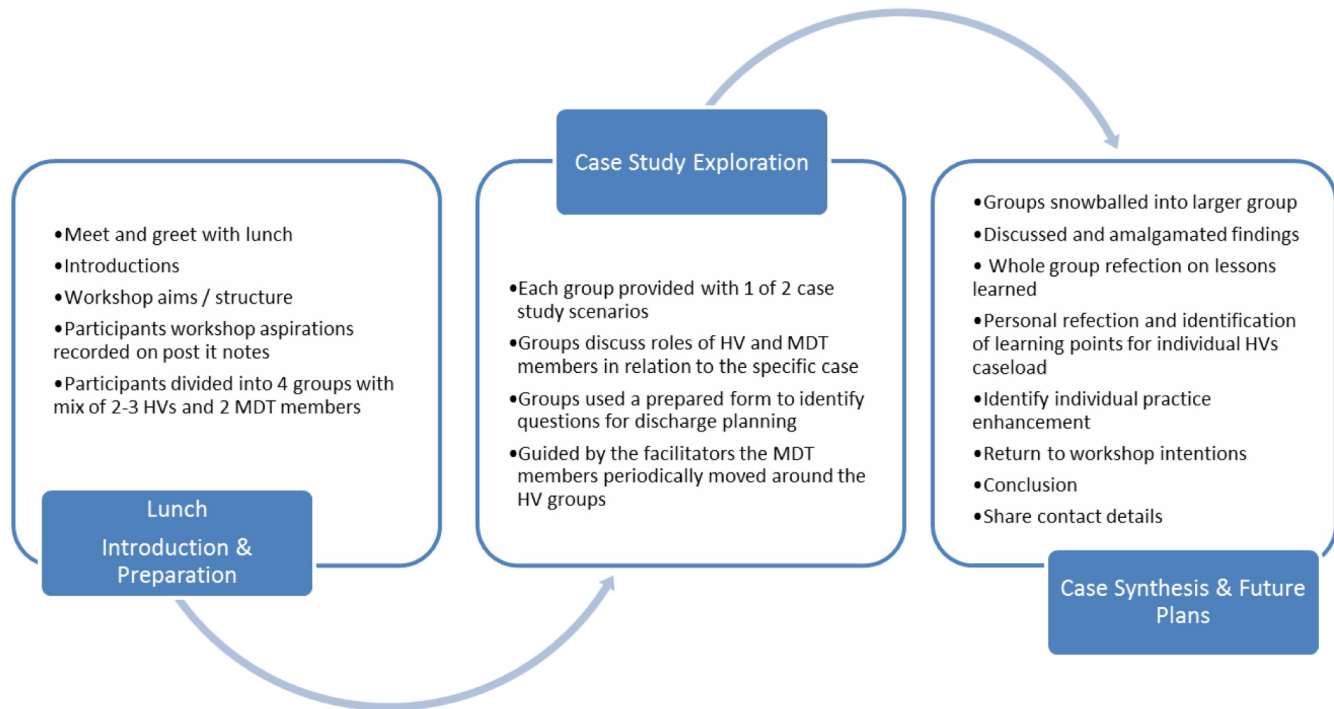
<p>perceptions of:</p> <ul style="list-style-type: none"> • The workshop (aims, relevance, structure and organisation); • Any gains from attending (knowledge, skills, insight, understanding); Networking; • Reflections on potential value. 		
<p>Interviews : Short and Medium term (retrospective)</p> <p>Narrative style interviews~ 45 minutes duration. In the short term (approx. 3 months post-workshop)</p> <p>Covering: Activity; Relevance and application of the workshop to everyday practice; Perceptions of worth and value of attending the workshop.</p> <p>In the medium term (6-8 months post-workshop~ 45 minutes duration) Also including: putting learning into practice; whether learning had been used in ways other than with babies ~1 year in age; perceptions regarding factors supporting or hindering the embedding of learning gained at the workshop into practice.</p>		<p>X</p> <p>X</p>

Table 3: Questionnaire results

Question	Answers / results	Yes	No
1	Were there any additional or alternative aims you would have liked included?	1	14
2	Did the session provide relevant information regarding the management of babies with complex health / developmental needs?	14	0
3	Do you feel you gained any new knowledge/skills/insights from attending the session?	14	1
4	Did the organisation and facilitation of session (e.g. pairing people, people moving around, the diagram to write on) help you understand how you could apply any learning gained to your practice?	14	1
5	Do you feel the study day enhanced your understanding of others professional roles?	14	1
6	Do you feel the session activities were relevant to your everyday practice?	14	1
7	Did the session provide opportunities to talk with other health visitors with case-loads which include babies and children with complex health and developmental needs?	12	3
8	Did you feel the session organisation facilitated interaction and engagement?	15	0
9	Did the session give you any new ideas or thoughts for your practice?	14	1

Highlights

- Multidisciplinary interactive CPD can facilitate learning, networks and confidence
- Selfefficacy and perceptions of content appear as mechanisms influencing attendance
- Together reciprocity, relevance and interactivity may prompt emotional safety
- Emotional safety during a workshop facilitates social capital development
- Attendance gains can translate into practice changes sustained in the medium term



Legend

HV = Health Visitor. In the UK Health visitors are qualified and registered nurses or midwives who have chosen to gain additional training and qualifications as specialist community public health nurses. Their additional training enables them to assess the health needs of individuals, families and the wider community to promote good health and prevent illness. They work mainly with children from birth to five years and their families and may also work with at-risk or deprived groups such as the homeless, addicts or travellers (NHS Health Education England)

MDT = Multi-Disciplinary Team. In Community Children's Nursing this could for example include: Health Visitor, School nurse, parents or carers, specialist nurses, Social worker, Paediatrician, Occupational therapist, Physiotherapist, speech and language therapist, care coordinator, individuals from local charities, voluntary sector etc. A multidisciplinary approach involves drawing appropriately from multiple disciplines to explore problems outside of normal boundaries and reach solutions based on a new understanding of complex situations. (NHS England 2014)

Figure 1

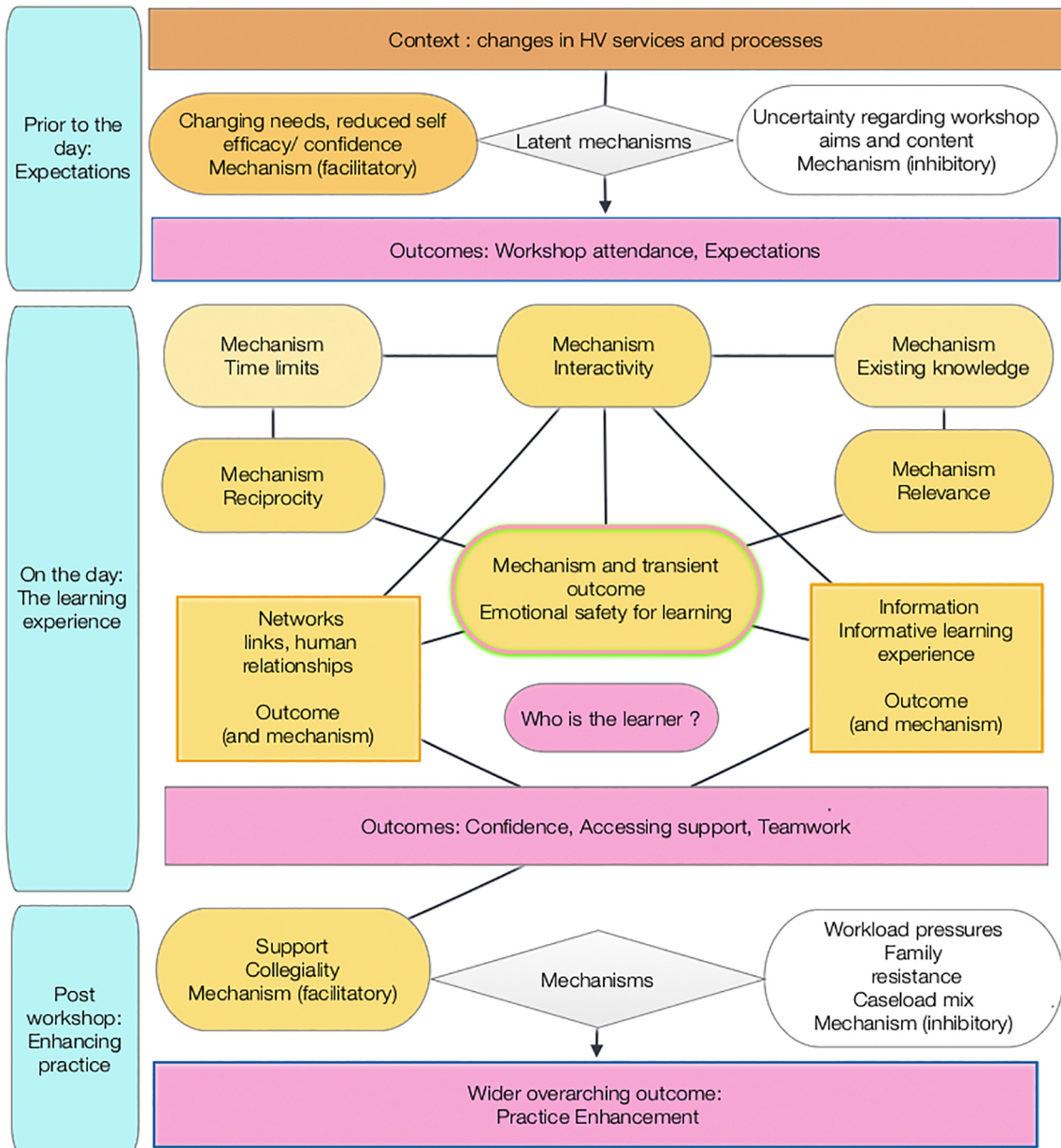


Figure 2